

## Correspondence

### *Gulf casualties*

DEAR SIRS

It seems increasingly likely that a major land battle will soon be fought in the Middle East. The NHS has been asked to prepare to treat significant numbers of physically injured casualties. Mental health services will need to offer support and advice to these patients and their relatives if the experience of recent conflicts in Northern Ireland (Curran *et al*, 1990) and the Falklands War (Jones & Lovett, 1987) are anything to go by. Not unreasonably, the Army has deployed the majority of its uniformed psychiatric personnel to the war zone where they will principally treat acute stress reactions (battleshock) according to the principles of forward psychiatry (Richardson, 1978).

It seems to us that there may possibly be a relative lack of expertise left in the UK to advise on specific military aspects of such problems as post-traumatic stress disorder. Here in Northallerton we have a fairly unique situation where 50% of our consultant staff have had recent experience with the Royal Army Medical Corps. If we can offer advice to our colleagues anywhere within the UK on this subject, we would be delighted to do so and we can be contacted on Northallerton (0609) 779911 extension 3927/4202.

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### *References*

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### *Medical audit in a lithium clinic*

DEAR SIRS

We chose to audit 18 years' experience in a lithium clinic to examine the quality and cost effectiveness of the service. The case notes of 150 patients in the West Norfolk and Wisbech Health Authority taking lithium for one or more years were examined. Except for

19 cases, all records were complete. We compared our results with a prospective study from a lithium clinic by Vestergaard & Schou (1988). Unipolar was defined as in their paper but bipolar disorder, grades 1, 2 and 3 according to Akiskal (1985). Where data were lacking, comparisons were made with other publications.

The average patient age was 54 years, 65% were female and 35% male. Their patients had an average age of 42.6 years but 80% were female. On lithium, 66% of our patients were diagnosed as bipolar, 29% unipolar and 5% miscellaneous, compared to their figures of 38%, 27% and 35% respectively.

Our patients had one episode of illness every 2.1 years before but every 4.6 years on lithium treatment. This translated into 0.74 episodes before and 0.21 episodes during lithium treatment per year, which was a highly significant reduction ( $P < 0.001$ ). Their patients had one episode of illness every 2.3 years before lithium but further data are unavailable.

The mean serum level over the 18 years and for 1989 was 0.63 mmol/l. The mean daily dose was 789 mg, approximately equivalent to 20.6 mmol of lithium. Eighty-eight per cent took Priadel, 7% Camcolit, and 5% Litarex. Seventy-six per cent of patients took lithium at night only, 13% twice daily, 6% in the morning, 4% three times, and 1% four times daily. Their mean daily dose was 23.2 mmol and mean serum level 0.68 mmol/l. Most of their patients took Litarex, twice daily.

The mean frequency of lithium, thyroid and renal function monitoring was once every 1.5, 6.6 and 7 months respectively, and for the year 1989, once every 1.7, 4.6 and 4.8 months respectively. In 1989, 1,075 lithium, 390 thyroid function and 370 creatinine tests were done on our patients at a total cost of £2,067.50 or £13.75 per patient. No comparable figures are available in their paper. Our figures, except for 1989, compare well with recommendations for lithium sampling of once every 1–3 months and renal/thyroid testing every 6–12 months (NIMH/NIH, 1985).

Eleven per cent developed hypothyroidism needing replacement therapy, and one patient became thyrotoxic. They give no data on thyroid disorders but our figures compare well with a published prevalence of lithium-induced hypothyroidism of 5–30% (Jefferson *et al*, 1987).

A tremor was developed by 3%; 15% of their patients developed a tremor initially which dropped after five years to 3–5%. Weight gain was a complaint of 2.6% but lithium was the sole treatment in